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PROBLEMS IN IMPLEMENTING MENTAL HEALTH AND MENTAL RETARDATION PROGRAMS[1,2]

by David J. Vail, M. D.[3]

I have been asked to comment on problems with respect to the development of federally-sponsored programs on mental health and mental retardation. I am glad to do so. However, I fear that I am in danger of being type-cast as the chronic complainer. Though I have been critical of the NIMH and the Department of Health, Education, and Welfare, I believe responsibility for the problems is more widespread.

In the short time available I will briefly describe a few problems as I see them.

1. Paperwork and clutter

   Speaking as the representative of the first state to submit a comprehensive community mental health centers construction plan, I can tell you that the amount of paperwork and busywork is unimaginable. The NIMH can take direct action to reduce this if they choose to. This problem is a very serious one, in my opinion; but easily solved.

2. Categories

   This goes outside the NIMH and is a Departmental problem. Possibly it is a problem for the entire Executive Branch, and the Congress as well.

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1 Remarks to American Medical Association Conference on Mental Health, Chicago, Illinois, March 6, 1965.

2 From the Department of Public Welfare, State of Minnesota

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The humanitarian programs are necessary. But there is a problem in the administration of them. It appears that the biopsychosocial dysfunctions are broken down into tight little categories. Each category has its narrow objectives, receives its own batch of money and has a specialized staff assigned to shepherd the particular program. The result is rivalry and confusion. The state operators feel this keenly as multiple forces converge. Each category has its own State Plan. In the Minnesota Department of Public Welfare, for example, we write each year State Plans for Public Assistance, Rehabilitation of the Blind, Crippled Children's Services, Child Welfare, and Mental Health. Mental Health includes the regular Grant-in-Aid category; most recently the State Plan for Comprehensive Community Mental Health Centers Construction; and (luckily a one-short deal) the so-called Comprehensive Plan to be completed this year. We can probably look forward to a Geriatric Care Plan if state hospital residents become eligible for OAA payments. Mental Retardation will have its own Plan, no doubt. The Minnesota Health Department has several categories of State Plans to contend with, including, of course, Hill-Burton. The Economic Opportunity Act has introduced an entirely new set of complexities.

I suspect that interest groups, such as the A.P.A., the N.A.M.H., the N.A.R.C., the A.P.W.A., the Child Welfare League, etc., have a great deal to do with the establishment and perpetuation of these categories.

3. Confusiasm

Now we enter an area for which the responsibility is borne not alone by the government departments but by citizen and professional groups.

This is especially pertinent to the so-called "Comprehensive Community Mental Health Centers" model. Our studies in Minnesota suggest that the plan has many basic flaws.

There are interesting semantics in the phraseology of my assignment for this panel: "problems with respect to the development of federally-sponsored programs." New programs should solve problems, not create them. The fundamental question is, Are the new programs worth developing according to the present design?

4. The Mental Health - Mental Retardation Split

The separation of mental health and mental retardation programs first appeared in the view of the state mental health authorities at the 1963 Conference of the Surgeon General. Our impression is that the split is now institutionalized and fixed in the bureaucratic structures of the Department of Health, Education, and Welfare, and the channels of communication and loyalty of that organization.

While this may be lamentable, I would remind this group that we in mental health and in the profession of psychiatry in particular have brought this on ourselves by neglecting the field of mental retardation for so long.

Mental Retardation needs its place in the sun. The chance to grow up away from the shadow of its big brother will not only be beneficial but essential. An eventual family reunion will be necessary. We feel that we will be able to accomplish this in Minnesota, as relationships are good and the government structures lend themselves to integration. Our worry is that pressures from the Department of Health, Education, and Welfare may delay or prevent this eventual reunion.

5. Money

There has been a great hoopla about restoring staffing funds to Title II of P.L. 88-164. I have been curious why there has not been similar pressure to provide funds for operating costs of community mental retardation centers. In terms of public accountability, one could show at least as much justification for mental retardation staffing as for the other.

Another problem in connection with money is that the existing proposal for staffing funds is for initiation only and phases out after 4¼ years. Without debating the merits or demerits of this concept, I must say that as a state program director I cannot be in the position of supporting or encouraging legislation at the federal level that is at some future time going to embarrass or further burden my own state legislature, to whom I am primarily accountable.

In summary, I find myself wistfully wishing for a House of Lords in Washington, with the power to delay legislation. I am convinced that another year or two in clarifying goals and objectives would do us all a world of good.

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(ADDENDUM: -- assuming time is available.)

Q. You have referred to "basic flaws" in the existing design of the comprehensive centers program. Could you be more specific?

A. The essential job in our view is to clarify the public concept in mental health and mental retardation. We are talking about the proper allocation

of public funds, under a public trust. This means that the public mandate must be spelled out.

1. First, we have defined two systems that merge into each other but are basically quite separate:

   (1) The public mandate system, operated by government in order to prevent, control, and reduce problems that the community collectively define as problems.

   (2) The voluntary market system, usually not operated by government but often subsidized by government. The market system makes available goods and services via open contracts between purveyors and customers, or recipients. Problems in this system are not defined by the public but immediately by the parties, privately or individually.

   One flaw in the comprehensive community mental health centers concept is that it is not entirely clear in which system the comprehensive center belongs. It appears to belong in the voluntary market system. The next question is, Is the best investment of the federal mental health dollar at this time in further subsidy of the voluntary market system?

2. Second, we have tried to define targets of public concern.

   Disordered behavior that causes public anguish is the broad order from which the classes are defined. The public will has allocated the accountability for one whole group of disordered behaviors -- crime and delinquency -- to correctional agencies. The public education and welfare systems have been allocated accountability

for certain problems involving disordered or maladaptive behavior. The public mental health agencies have been assigned the problem of major mental disorder. Agreement on definition breaks down at this point: I use the term major mental disorder to mean those behaviors of excessive unreliability or weakness that require separation from home, and some measure of control and/or basic support. This definition includes mental retardation, problems of the senium, and the increasing influx of juvenile behavior problems that for legal purposes fall on the "mental illness" rather than "delinquency" side of the line.

The comprehensive center documents speak of "treating mental illness in the community" but do not spell out "mental illness" any more precisely. Thus the target is still blurry. This is the second flaw.

The public cannot afford to invest its hard-earned money into programs that do not first and foremost attack the serious problems about which the public is most concerned. We believe that the first priority of investment aimed at preventing, controlling and reducing major mental disorder should not be in the market system but in the public mandate system: courts, probation offices; police and correctional systems; public schools; welfare departments; and public institutions operating under statutory authority and responsibility.

3. Third, we have tried to clarify authority and accountability. This is difficult to do. We are not aware of any real designation of accountability in connection with P.L. 88-164, other than internal

accountability (i.e., for the mechanics of the operation). This is the third flaw.

Accountability, not service, is what we need more of. Continuity of responsibility, not continuity of care, should be the watchword. Our studies lead us more and more to the idea that what may be needed at the community level is a public mental health officer, with statutory authority and responsibility clearly spelled out; similar to the Mental Welfare Officer in Britain -- a "duly authorized agent" as he is sometimes called.

4. The fourth flaw: a simple linguistic oversight. To plan, to prevent, to serve, are all transitive verbs. They have first and foremost direct objects: To plan some thing, to prevent some thing, to serve some thing. They have next indirect objects: to plan some thing for some purpose, to prevent some thing for some purpose, to serve some thing to some one. We have forgotten all this. These lovely verbs have been weakened to ordinary nouns that are treated like commodities -- planning, prevention, services -- that need have no objects but are treated as ends or good things in themselves.

5. The fifth flaw: a constricted model. The plan is for a hospital-like facility, staffed by professionals whom we now accredit in a limited number of fields. Is there room in the comprehensive community mental health program concept for the full use of non-accredited professionals (i.e., professionals not accredited in the classic mental health fields), for volunteers, for so-called

indigenous non-professionals? Is there room for experiments in transportation or communication? A day-care program as classically defined would not be feasible in our sparsely-populated northern regions. But a rapid-transit bus or railroad that brings families to the state hospital and funds or facilities to lodge them might be. Is there room for full use of the power that lies now dormant in the state mental hospital and other components of the public system? We believe further thought should be given to these questions.